



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

***7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645***

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

BAYLOR HEALTH CARE SYSTEM  
2001 BRYAN STREET SUITE 2600  
DALLAS TX 75201-3005

#### **Respondent Name**

ASSOC CASUALTY INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 53

#### **MFDR Tracking Number**

M4-07-3436-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "Part of claim pd but denied other charges as not authorized 4.4.06 Baylor contacted insurance company and spoke with Maria she said adj'r Lisa Dean fax 512-345-1972 for pre auth return fax from Lisa no pcr-st it it emergency and claim just opened yesterday onsite cert to transfeer to another hospital, patient was transferred from Medical Center of Lewisville to Baylor for emergency services trauma ICD-9 should be paid at 75% + implant cost +10%." [sic]

**Amount in Dispute:** \$34883.79

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "The above requestor is correct in that trauma admissions do not require preauthorization, however, after the first 48 hours preauthorization should have been requested. Per Preauthorization Rule 133.304, 'All inpatient hospital admission including the principal scheduled procedure(s) and the length of stay' require precert. Therefore, denial was correct, and no additional amount is owed."

**Response Submitted by:** Lisa Dean, Association Casualty Insurance, P.O. Box 9728, Austin, TX 78766

### ***SUMMARY OF FINDINGS***

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2006	Inpatient Surgery	\$34883.79	\$0.00

### ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. 28 Texas Administrative Code §134.600, effective March 14, 2004, 29 TexReg 2360, requires preauthorization for non-emergency inpatient hospital services.
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. This request for medical fee dispute resolution was received by the Division on January 29, 2007.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated May 17, 2006

- 45-Contract/Legislated fee arrangement exceeded.
- 601-Non-Physician provider reimbursed @ 75%.
- W10-Payment based on fair & reasonable methodology.
- 504-Allowed fee appears reasonable for services.
- 62-Pre-certification/authorization absent or exceeded.

Explanation of benefits dated September 8, 2006

- 601-Non-Physician provider reimbursed @ 75%.
- W10-Payment based on fair & reasonable methodology.
- 504-Allowed fee appears reasonable for services.
- 62-Pre-certification/authorization absent or exceeded.

## **Findings**

1. The Respondent raised the issue of a contract; however, a review of the submitted EOBs does not support a contractual reduction was taken. The respondent did not submit a copy of a contractual agreement to support this EOB denial; therefore, the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
2. The requestor billed \$52,541.14 for inpatient hospital surgical services rendered from March 31, 2006 through April 7, 2006. The respondent paid \$1617.38. The respondent denied reimbursement for the remaining services based upon "62-Pre-certification/authorization absent or exceeded."  
The requestor disagrees with the respondent and contends that additional payment is due because this admission was for emergency services for a trauma diagnoses.  
The respondent states in the position summary that "The above requestor is correct in that trauma admissions do not require preauthorization, however, after the first 48 hours preauthorization should have been requested. Per Preauthorization Rule 133.304, 'All inpatient hospital admission including the principal scheduled procedure(s) and the length of stay' require precert. Therefore, denial was correct, and no additional amount is owed."
3. 28 Texas Administrative Code §134.600(b)(1) effective March 14, 2004, states that "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (h) or (i) of this section only when the following situations occur:  
(A) an emergency, as defined in §133.1 of this title (relating to Definitions);  
(B) preauthorization of any health care listed in subsection (h) of this section that was approved prior to providing the health care;  
(C) concurrent review of any health care listed in subsection (i) of this section that was approved prior to providing the health care; or

(D) when ordered by the commission.”

The claimant sustained a compensable injury on March 30, 2006 when a 1,100 pound pole fell on his legs.

The respondent does not dispute that the initial treatment was for a medical emergency and did not require preauthorization. The respondent contends that after the initial forty eight hours the hospitalization required preauthorization.

4. 28 Texas Administrative Code §134.600(i)(1) effective March 14, 2004, requires preauthorization for concurrent review for an extension of “inpatient length of stay.”

The Discharge Summary indicates that the claimant was transferred to Baylor University Medical Center on March 31, 2006 “because of bilateral tibial fractures. He was neurovascularly intact with no compartment syndrome.” The claimant was “monitored for several days. He underwent surgical intervention on April 3. There was a significant amount of confusion which was felt to be related to fat embolism. He was followed by the Internal Medicine Service along with us. He did develop pneumonia. He was placed on Augmentin for his pneumonia. Postoperatively he started therapy. When he cleared therapy and his pneumonia was stable he was discharged home.”

On April 3, 2006 the claimant underwent surgery for treatment of bilateral tibia and fibula fractures.

The requestor states in the position summary that on April 4, 2006 “Baylor contacted insurance company and spoke with Maria she said adj'r Lisa Dean fax 512-345-1972 for pre auth return fax from Lisa no pcr-st it it emergency and claim just opened yesterday onsite cert to transfeer to another hospital...” [sic]

The Division finds that the requestor did not obtain preauthorization approval for concurrent review for inpatient hospitalization in accordance with 28 Texas Administrative Code §134.600(i)(1); therefore, additional payment is not recommended.

5. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former Division rule at 28 TAC §134.401(c)(5)(A), which requires that when “Trauma (ICD-9 codes 800.0-959.50)” diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 823.82. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
6. 28 Texas Administrative Code §133.307(c)(2)(C), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include “the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division.” The requestor listed the disputed date of service as 03/31/06 on the *Table*; however, the Division finds that the total charges listed were for dates of service March 31, 2006 through April 7, 2006. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under 28 Texas Administrative Code §133.307(c)(2)(C).
7. 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include “how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues.” Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of 28 Texas Administrative Code §133.307(c)(2)(F)(iii).
8. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of 28 Texas Administrative Code §133.307(c)(2)(F)(iv).
9. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
  - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* states that

"Part of claim pd but denied other charges as not authorized 4.4.06 Baylor contacted insurance company and spoke with Maria she said adj'r Lisa Dean fax 512-345-1972 for pre auth return fax from Lisa no pcr-st it it emergency and claim just opened yesterday onsite cert to transfeer to another hospital, patient was transferred from Medical Center of Lewisville to Baylor for emergency services trauma ICD-9 should be paid at 75% + implant cost +10%" [sic]

- The requestor does not discuss or explain how payment of 75% of charges + implant cost + 10% would result in a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to comply with preauthorization requirements outlined in 28 Texas Administrative Code §134.600. The Division further concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.307(c)(2)(C), §133.307(c)(2)(F)(iii), §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Manager

\_\_\_\_\_  
Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.